Chapters II & III, Section 40, Home Health Services, MMAM
Comments & Responses
In Follow-up to the Trainings Sessions on November 15 & 16, 1999

This memo provides the Department's responses to the key issues identified during the training sessions on the Medicaid Home Health Policy. Based upon the comments received, the Department is issuing revised procedures for the prior authorization process. These are described below. See the attached list of enclosures for the documents included in this follow-up packet.

Prior Authorization requirements

For Nursing, HH aide and Medical Social Services:
Until further notice, each new admission, or re-admission shall be considered a new start of care; prior authorization is not required until a second (or third, etc.) consecutive certification period is needed. The "initial certification period" shall mean any new admission or any re-admission subsequent to a discharge from HH services. This will eliminate delays around emergency, late night or weekend admissions. HH agencies can begin care on a timely basis for individuals who meet the eligibility requirements. The Department will be monitoring for frequent and repeat admissions and discharges.

On or after 1/1/2000, **current** adult HH clients who will **continue** to need HH services for a **consecutive certification period**, shall require a prior authorization from the Goold Assessing Services Agency.

For continuing care, in order **to avoid a gap in reimbursement**/coverage, a request for an assessment must be submitted to the Goold Assessing Services Agency 5 calendar days prior to the end date of the client's current classification period.(See Sec.40.07-1(E)) The **"classification period"** is authorized by Goold. If the client does not have an authorized classification period, it shall be the end date of the current **"certification period**" from the HCFA 485.

HH agencies will **not** be held responsible for determining whether a client has been served by another HH agency. The HH agency will be responsible only for requesting a prior authorization when their client needs to continue HH services into a consecutive certification period.

OT, PT, Speech Services Only
Counting therapy visits utilized by a consumer is the responsibility of the HH agency delivering the therapy visits. For consumers who are only receiving therapy services, after an adult consumer has used 20 PT or OT visits, or 35 speech/ language therapy visits, the HH agency must request a prior authorization in order to continue providing these services during the same state fiscal year.

- **Question:** How can HHAs verify whether a patient has already used the initial certification period and requires a prior authorization. HHA's report it is unrealistic to ask the physician. Will the HHA be at risk if they serve a client who required PA, but didn't get it? Will services not be covered if delivered to a person who required PA, but the HHA did not know this.
  Response: Until further notice, HH agencies will **not** be held responsible for determining whether a client has been served by another HH agency. The HH agency will only be responsible for requesting a prior authorization when their client needs to continue HH services into a consecutive certification period with their agency.

  A HH agency will **not** be held responsible for determining whether a client has been served OT, PT, or Speech services by another HH agency during the fiscal year. A HH agency is only responsible for tracking its own service units, and requesting PA when it has reached the service limits.

- **Question:** Who is responsible for hospital patients? The hospital discharge planner or the HHA?
- **Response:** Hospital discharge planners are responsible for arranging for the discharge of patients, including the assurance that HH services are available prior to discharge. The new prior authorization procedures (see above) should remove obstacles to having timely HH services in place.

- **Question:** Is coverage by Goold available on the weekends & nights?
- **Response:** No, with the exception that Goold must respond within 24 hours of a request for an assessment from the hospital setting. However, with the revised prior authorization procedures, clients who are new admissions or readmissions do not require PA.

- **Comment:** Concern was expressed regarding the timing of a HCFA 485/ request for an assessment and Oasis reporting. The Department's time frame to request an assessment 5 days prior to the end of the classification period does not work out well with the Oasis reporting timeframe, which must also be done within the 5 days prior to the end of the certification period. HHA's want to use the Oasis findings to update the HCFA 485.
- **Response:** The Division of Licensing & Certification has reviewed this comment and responds that HH agencies typically have the new HCFA 485 ready well before (i.e. 2 weeks) the end of the current certification period. We understand it is common practice for HH agencies to have the HCFA 485 ready and then to update it with the physician's verbal orders as needed. Therefore, the Department believes the 5 day

timeframe for requesting an assessment for PA & submitting the HCFA 485 should not pose a difficulty.

Transitions to other LTC Programs

- **Question:** The HH agency needs to be notified of the date on which a client is transferred/ starts receiving services from another provider. The HHA is concerned about delivering services, and not receiving reimbursement, to a client who has been transferred to another provider. How will HHAs be notified of the effective date of a transfer? Can EIM notify the HHA when a consumer starts PDN or Waiver services, when the consumer is in awaiting placement status? HHAs have no way of knowing when another provider starts services.
- **Response:** Goold will notify agencies by FAX regarding the assessment outcome and Awaiting Placement status. Elder Independence of Maine (EIM) will notify the HHA prior to the start of other services.

- **Comment:** What is the policy on transferring a HH patient if the Private Duty Nursing Agency is unable to fully staff the plan of care?
- **Response:** EIM will not start services for a HH consumer with Awaiting Placement status until the entire plan of care can be implemented by the LTC provider. As necessary, Awaiting Placement status will be extended to allow continued coverage of HH services.

- **Comment:** When does Awaiting Placement apply?
- **Response:** Awaiting placement status may be given to a current Home Health consumer who does not meet the new HH eligibility requirements, but does meet eligibility requirements for Sec. 96 Private Duty Nursing Services, or any Home and Community-Based Services Waiver program, or Section 12, Consumer Directed Attendant Services. Awaiting placement classification requires an assessment and determination by Goold. Generally, Goold will give a 30 day classification. Goold will authorize extensions as necessary, when requested by EIM

Discharge

- **Comment:** No one has notified the clients of the changes in HH rules. HHA's should not have to be the bearer of bad news. Will the Department issue a notice to consumers regarding the new policy?
- **Response:** The Department does not plan to send out a notice to all Medicaid HH clients regarding the policy changes; we believe this would create confusion and some undue distress among clients since most clients will not be affected. The Department feels it would be more appropriate to handle discharges on a case by case basis. The Department has attached an official departmental discharge notice. Home

Health agencies will provide a copy of this notice to clients as necessary. Also attached is a sample of how the notice is completed and fair hearing rights.

- **Comment:** What are the consumer notification requirements for discharge? How do these work with the Licensing requirements for discharge?
- **Response:** 14 days prior to the end of a certification period the HH agency will give the consumer a discharge notice, if the consumer is found not eligible for HH services by your agency. The Department, and its Authorized Agent, reserve the right to issue its standard 10 day discharge notice anytime it conducts an assessment and determines an individual is not eligible for Sec.40 services.

- **Comment:** Is one discharge notice sufficient for a consumer who is moved to awaiting placement status; is a second discharge notice required when services cease under awaiting placement?
- **Response:** Generally, one discharge notice will be sufficient to notify a consumer that he/she is no longer eligible for HH services and will be no longer be served by the HH agency once a new provider, i.e. PDN, begins to deliver services.

General

- **Question:** Clarify the application of the "intermittent" requirement.
- **Response:** The application of "intermittent" nursing care criteria, under the Section 40 Home Health rules, shall be consistent with the way in which it is applied by Medicare Home Health regulations. Qualifying criteria for intermittent skilled nursing care is: skilled nursing care that is needed on fewer than 7 days each week; or, less than 8 hours of each day; for periods of 21 days or less; with extensions in exceptional circumstances when the need for additional care is finite and predictable. Nursing and home health aide services are covered if they are furnished (nursing and aide service combined) less than eight hours per day; and 28 or fewer hours each week; (Or subject to review on a case-by–case basis as to the need for care, less than eight hours each day and 35 or fewer hours per week).

- **Comment:** How should the RN & HHA entrance and exit times be documented? Why does the Department need a total, and for what time period? Where should this be documented. How does the Department intend to use this data? Is the Department willing to accept time totals on an audit basis? ie If the Department selects records on an audit basis, the HH agency could total the time for the selected audit records.
- **Response:** Entrance and exit times shall be kept on flow sheets in all patients' records. The time should be totaled for each visit. The billing units on a claim do not precisely reflect the record. The Surveillance & Utilization Review Unit will use this

information in record reviews and to verify intermittent and part-time nursing services. It will also be used by the Division of Reimbursement to analyze costs of the program.

- **Comment:** Can the homebound exemption that "outpatient services are not available within a 20 mile radius of the consumer's home" be used when not available means there are no openings or there are waiting lists?
- **Response:** Yes, if the consumer is on a waiting list for outpatient services, and this is dated and documented in the medical record, this can qualify as a homebound exemption. Of course, all other HH eligibility requirements must be met.

- **Question:** Were physicians notified of the changes to Home Health Policy?
- **Response:** Yes, a letter regarding Home Health policy changes was sent out to physicians from the BMS Medical Director, Dr. Tim Clifford.

- **Comment:** Will BMS prepare and mail out the new provider agreements?
- **Response:** The new provider agreements were mailed out by the Division of Financial Services the week of 12/13/99. HH agencies must return a signed agreement to BMS.

- **Question:** How should supplies be billed?
- **Response:** The HHA can bill for the routine supplies which are essential to carry out the physician's plan of care. These supplies must be itemized and billed at acquisition cost. Non-routine supplies require must be ordered through Sec. 60 Medical Supplies and Durable Medical Equipment.

- **Comment:** Start of care date—The Dept's required admit form w/ SOC date may not match the original SOC date on the HCFA 485. HHA computer system would require a "discharge" in order to change the date on the HCFA 485.
- **Response:** It is acceptable if the dates do not match on these two forms. The start of care date for the admit form begins with the admission or re-admission date.

- **Question:** How will HHA deal w/ transportation agencies? What is the criteria for coverage?
- **Response:** Transportation agencies are required to respond to (including alternative arrangements) all requests for transport to Medicaid services.

- **Question:** Under the severe and disabling mental illness eligibility criteria what is meant by additional services require prior authorization? What about necessary prn

nursing visits for assessment or treatment other than medication prefill? Or does this refer to other disciplines?

- **Response:** All medication administration and monitoring services which are required for the treatment of a patient's severe and disabling mental illness are covered, pursuant to physician orders and as specified in the plan of care. For additional services the revised prior authorization requirements apply.

- **Comment:** How do the "severe & disabling mental illness' requirements (40.02-3) apply to mental health occupational therapy.
- **Response:** They don't. Severe & disabling mental illness applies to RN medication administration and monitoring services only.

- **Comment:** What are the NF eligibility requirements for home health services ?
- **Response:** The NF eligibility criteria are set forth in Section 67.02-3.

Does this patient qualify?

We received several questions asking whether or not a particular patient with specified needs would qualify for HH services. As a rule, all eligibility requirements must be met. Physicians are responsible for certifying homebound status or otherwise establishing when it is medically contraindicated for a particular patient to utilize outpatient services. We cannot make determinations without complete information. Remember, children have additional options for services under EPSDT.

- **Comment:** Would the following be covered: a blind diabetic, who has no one to help him, who requires pre-filled syringes?
- **Response:** Yes, if physician certifies that client is homebound, or otherwise that outpatient services are medically contraindicated.

- **Comment:** Would kids with mental illness continue to qualify for home health services if they are also receiving outpatient services from a psychiatrist, counselor, etc.? Many receive adjunct services at home due to high acuity, safety issues and or recent hospitalization.
- **Response:** Coverage for HH services requires all eligibility requirements must be met. Physicians are responsible for determining exemptions to the homebound requirements. Physicians determine when using outpatient services are medically contraindicated for a particular patient. The reasons must be documented.

- **Question:** What about when CDS refers kids who are not homebound, but there are no other providers available?

- **Response:** A CDS referral does not override Medicaid policy. All HH eligibility requirements must be met. Children have EPSDT service options available too.

- **Question:** What about HH services to MR clients? Not homebound. Many receive therapeutic blood monitoring.
- **Response:** All HH clients must meet the eligibility requirements for services. Physician determines when using outpatient services is medically contraindicated Sec.96 Private Duty Nursing Services is adding coverage for venipuncture only services.